Alabama Department of Mental Health and Mental Retardation Criticality Information Summary – Revised 8/04

Identifying Information:

Person's SSN: __ __ __-__ __-__ __ __ __; Medicaid # __ __ __-__ __ __-__ __-__ __ __ __-__

Person's name: Last_____; First_____; MI_____

Person's address: Street_____; City_____

State_____; Zip Code_____; County_____

Person's DOB: __ __/__ __/__ __ __ __; Gender M F ; Region of residence: 1 2 3 4 5

Person's Ethnicity: __Black; __White; __Alaskan Native; __American Indian; __Asian;

__ Pacific Islander; __Multi-Race; __Other

Hispanic Origin: __Not Hispanic; __Puerto Rican; __Cuban; __Other; __Mexican

Case Mgmt Agency Provider Number __ __ __ __ __ __ __ __ __

Case manager (or other) completing this assessment: _____

Whom did you interview to complete the checklist? _____

Date on which assessment is completed: _____

- Is the person currently enrolled in:
  ___The MR Waiver; ___The LAH Waiver; ___Other Waiver?
- Does the person currently have Medicaid? ___Yes ___No

What waiver-reimbursed services does the person need (and is waiting for)? List the service(s) within Service Groups (Residential, Day and Supports) and note briefly why each service is needed.

Residential

Day

Supports

Check one of the following and complete the requested information:

___The person is not receiving any services at this time; or

___The person is receiving some waiver-covered services, even if the waiver is not funding them; (List services being received and indicate the funding source)

Include any notes or comments about this person's need for services. (Optional)

Category 1: Health and Safety
Definition: The service/support is required to ensure the health and safety of the person, or of others. Not providing the service/support will place the person, or others, at risk of illness, injury, abuse or other serious harm. In order to be categorized as needed for health and safety, the degree of risk must be greater than 50% without intervention.

___**Check if the need for the service/support meets this definition, and**
___Check if the risk is imminent—definite and immediate (within 30 days), and
___Check if the person has no residence (is homeless)

For category 1, also fill out the Medical and Behavioral Support Checklist.

Service group(s) needed because of the definition in this category:
___Residential
___Day
___Supports

Indicate by checking if Medicaid matching funding is available:
___From a State Agency (other than DMH/MR)
___From a local governmental agency

Category 2: Family Support
Definition: The service/support is necessary to help the family care for their family member in their home or the service/support is necessary to provide an alternative because the family's support is not available.

___**Check if the need for the service/support meets this definition**, **and**
___Check if the primary caregiver has died or has a terminal diagnosis, and/or
___Check if the primary caregiver has other chronic health conditions that significantly limit the ability to provide for the person, and/or
___Check if the primary caregiver is over age 75, and/or
___Check if the primary caregiver is between 60 and 75 years of age, and/or
___Check if the primary caregiver has been divorced or separated from spouse within the last 6 months, or if another member of the immediate family has experienced a serious illness. , and/or
___Check if more than one member of immediate family is eligible for services from the Division of Mental Retardation, and/or
___Check if the primary caregiver has experienced an unplanned loss of employment within the last 6 months.

For category 2, also fill out the Medical and Behavioral Support Checklist.

Service group(s) needed because of the definition in this category:
___Residential
___Day
___Supports

Indicate by checking if Medicaid matching funding is available:
___From a State Agency (other than DMH/MR)
___From a local governmental agency

Category 3: Individual Daily Living Supports
Definition: The service/support is necessary to help the person perform activities of daily living or to help the person in living independently or developing the skills needed to live more independently.

___**Check if the need for the service/support meets this definition, and**
___Check if the person lives independently (or with family) and is at risk of moving to a more restrictive setting (i.e., a residential program) without the requested service/support. If so, determine if one of the following needs to be checked, too.
___Check if the risk of moving is immediate (within 30 days).
___Check if the risk of moving is prospective (likely within one year).

Service group(s) needed because of the definition in this category:
___Residential
___Day
___Supports

Indicate by checking if Medicaid matching funding is available:
___From a State Agency (other than DMH/MR)
___From a local governmental agency

Category 4: Inclusion Supports
Definition: Service/support is required to address barriers that might keep the person from participating in meaningful community activities.

___**Check if the need for the service/support meets this definition**.

Service group(s) needed because of the definition in this category:
___Residential
___Day
___Supports

Category 5: Long Term Planning

___Check if the person is receiving residential services supported by an alternative funding source (DHR, Education) and current situation has a time limit (e.g., due to age) and the person is not able to return home. **OR**
___Check if the person is already receiving residential services funded by DMHMR but needs alternative or enhanced services/supports. **OR**
___Check if the family has long term planning needs, such as knowing that they will want residential placement sometime in the future (longer than one year, but no longer than 5 years—children cannot be considered in this category until they are at least 14 years old).

Service group(s) needed because of the definition checked in this category:
___Residential
___Day
___Supports

Medical and Behavioral Supports Checklist: Check all that pertain to the individual. Unless otherwise noted, the symptom or behavior must have occurred within the last year.

Medical

___ Chronic pain
___ Significant weight loss or gain (5% of body weight within last 30 days or 10% within last 6 months)
___ Frequent illnesses that interfere with the person and family's daily routines
___ Frequent injuries and/or falls that require medical attention
___ Seizures—frequent and uncontrolled and/or that required emergency hospitalization within the last year
___ Suctioning, tracheotomy, oxygen therapy, ventilator
___ Choking, choking precautions
___ Tube feeding and/or spoon feeding by caregiver
___ Incontinence; daily catheterization and/or bowel care
___ Person requires lifting for transfer that is difficult for caregiver(s)
___ Orthopedic conditions—scoliosis, hip dysplasia, contractures, etc.
___ Skin breakdowns

Behavioral

___ Made threats verbally and/or physically (with reason to fear physical harm)
___ Destroyed property
___ Ran away
___ Sleeplessness (has slept less than 4 hours/night, 5 days a week, for a month)
___ Abused alcohol or substances
___ 2 or more medications used to treat mental illness and/or for behavior control
___ Harmed him- or herself
___ Harmed others, (others can include animals)
___ Ingested toxic and/or non-food substances or dangerous quantities of food
___ Made a suicide attempt or threat
___ Set fires
___ Was sexually aggressive
___ Physical restraint had to be used within last 6 months